# I. Providing Access to Health Care for Women and Girls

There are a variety of factors that affect a woman or girl's ability to access health care. For low-income women in particular, the list of access challenges can become quite long. Women and girls can experience linguistic or cultural barriers in finding health care providers who speak a familiar language and approach health care in a culturally familiar way. Women without access to transportation face the challenge of finding health care providers who are geographically accessible or conveniently located. Women with responsibility for young children or women struggling with job responsibilities face the challenge of finding the time to take care of their own health care needs.

One of the most significant barriers to health care access for women and girls is economic. Health care is extremely expensive to pay for out of pocket, and health insurance to pay for medical care is rapidly becoming less affordable. Even for women with publicly-funded health insurance, because of the rate structure by which these providers receive reimbursement for their services, finding health care providers in certain medical specialties can be a daunting task.

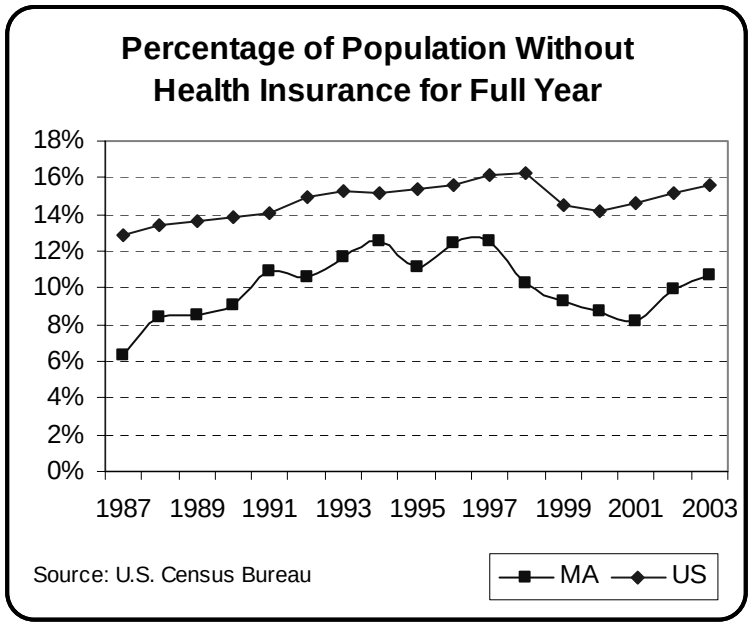
Poor access to health care has significant implications for all aspects of women's lives, including their ability to maintain their own health and well-being, their ability to care for their families, and their ability to meet the responsibilities of regular employment.

The Commonwealth plays several crucial roles in improving access to care for women and girls. One of the primary functions of the Massachusetts Department of Public Health and other departments within the Executive Office of Health and Human Services is to improve access to health care for vulnerable populations. In fact, the Commonwealth has recently reorganized the structure of these agencies in order to facilitate better coordination across the service spectrum and across age ranges. These departments identify areas of need within the Commonwealth, and develop targeted programs to serve the needs of particularly vulnerable populations, including girls and women of all ages. The services and supports directly provided by these agencies are an important component in the web of care for women and girls.

This report will discuss some of those efforts in a subsequent section. In addition to these direct services, however, the Commonwealth plays an important role in providing health insurance for a large segment of the population who would otherwise be uninsured.

## *Providing Health Insurance for the Otherwise Uninsured*

**Figure 28**

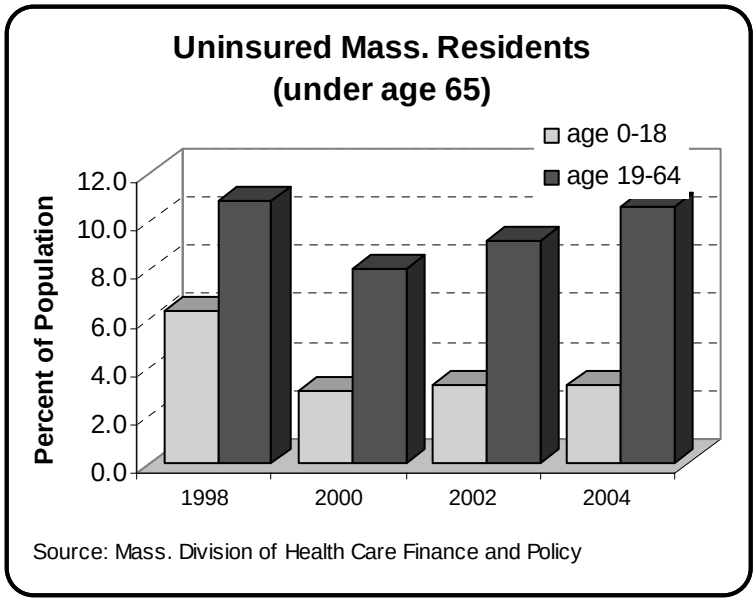



According to recent data from the Census Bureau, there are close to 45 million people in the United States who reported not having health insurance during 2003, almost one in every six persons, or 15.6 percent. In Massachusetts, the number is closer to one in every ten persons, or 10.7 percent of Massachusetts residents (see Figure 28). The Census Bureau estimates that in 2003 there were close to 685,000 individuals in Massachusetts without health insurance.[1]

Although the percentage of the population without health insurance has declined since the mid-1990s, the uninsured rate has increased since the economic recession and state fiscal crisis in the early part of this decade.

A recent survey published by the Massachusetts Division of Health Care Finance and Policy presents a similar picture. This survey showed that approximately 460,000 Massachusetts residents were without health insurance at the time of the survey in early 2004, close to 7.4 percent of the population (see Figure 29).[2] Although the rates of children without health insurance dropped markedly in the late 1990s with the introduction of state-supported targeted insurance programs and has stayed relatively stable at approximately three percent, the percentage of adults between the ages of 19 and 64 without health insurance has

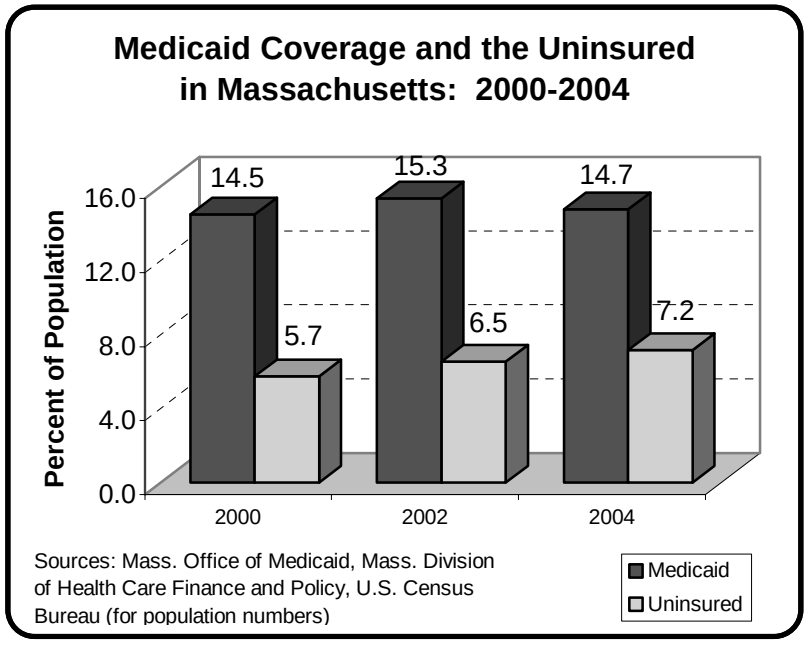
**Figure 29**



grown from 8.0 percent in 2000 to 10.6 percent in 2004 – almost as high as the percentage of uninsured adults in 1998 before the targeted insurance expansions were fully implemented.

In a recession, one might expect that joblessness and poverty would increase, thereby increasing the number of persons without private employer-sponsored health insurance. One might also expect that as private health insurance rates decline, and the portion of the state's population without health insurance grows, the state's safety net of public health insurance programs would increase to ensure that the Commonwealth's residents continue to receive health care.

**Figure 30**




Unfortunately, as Figure 30 demonstrates, publicly-funded health insurance enrollment through the state's Medicaid program declined after 2002, even as the portion of the population without insurance coverage rose during that time.

According to these data from the Office of Medicaid and the Mass. Division of Health Care Finance and Policy, the percentage of the total population without insurance rose from 6.5 percent to 7.2 percent between 2002 and 2004, and the percentage of the population covered by Medicaid declined from 15.3 percent to 14.7 percent.[3] (Every one-tenth of one percentage point represents more than 6,000 people.)

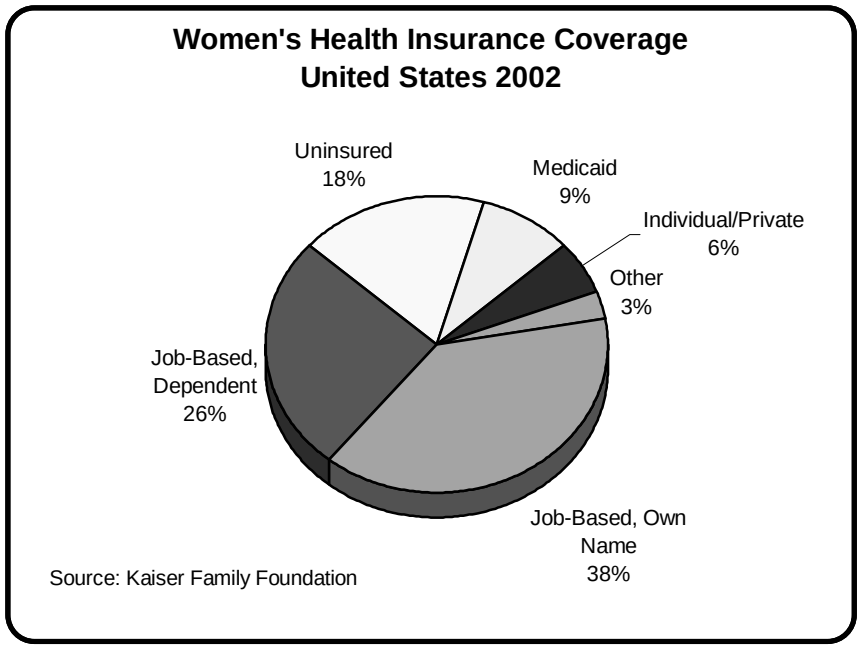
One of the factors that may have led to the decline in Medicaid enrollment was an explicit intention on the part of the Commonwealth to slow enrollment growth in reaction to fiscal concerns. According to a June 2004 statement to the federal Centers for Medicare and Medicaid Services, "many of the outreach and marketing efforts [for Medicaid enrollment] were scaled back beginning in 2002 to slow enrollment (rather than reduce or cap eligibility) in reaction to the state budget crisis. . . ."[4]

## Impact on Women and Girls

In Massachusetts, the health insurance rate is higher than the national rate, and Massachusetts also has a higher percentage of women with health insurance than the nation as a whole. Estimates from the Massachusetts Department of Public Health indicated that in 2002 approximately 9.9 percent of men and 5.9 percent of women were without health insurance.[5] One of the reasons that women have a better insured rate is that they are more likely than men to be eligible for publicly-funded health insurance.

Women in general have a different pattern of health insurance coverage than men, and even though they are more likely to be insured, their insurance is also likely to be more at risk than is men's. Although women are just as likely as men to have job-based health insurance overall, they are less likely to be insured through their own job, and more likely to have dependent coverage from a spouse. Because women are more reliant on dependent coverage than men, they are more vulnerable to losing health insurance if they become divorced or widowed, and are also more vulnerable to changes in their spouse's employment or health insurance status.

**Figure 31**



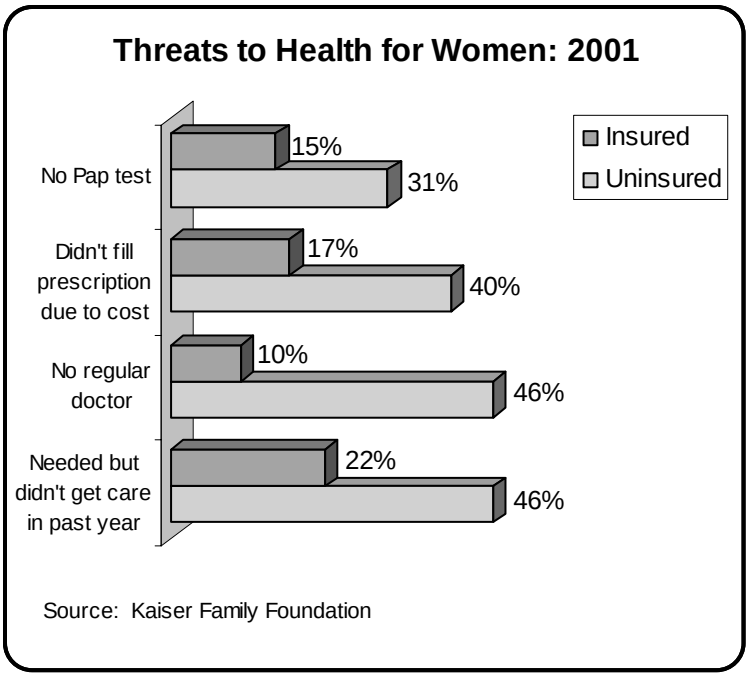

In 2002, approximately 38 percent of women between the ages of 18 and 64 nationally had their job-based insurance from their own job (see Figure 31), compared to 53 percent of men. Some of the difference in these rates can be explained by the fact that women are less likely than men to work full-time, and are therefore less likely to be eligible for full employment benefits.

Women are also more likely than men to be working in low-wage employment that does not provide extensive health benefits. While only 13 percent of men receive health insurance as a spouse's dependent, 26 percent of women have dependent coverage.[6] According to national data, women at the greatest risk of being uninsured are younger, are poor or near-poor, and are likely to be women of color. Women without health

insurance are at greater risk for poorer health outcomes, and they are more likely to postpone care or forego preventive care entirely.

Health insurance is extremely important to the health care of women and girls. Having health insurance is a major determinant of whether women have access to health care services, and whether women will actually receive appropriate health care over the course of their lifetimes. According to data from the Kaiser Family Foundation (see Figure 32), women without health insurance are much more vulnerable to a number of significant threats to their health than are women who are insured.

**Figure 32**




Uninsured women are more than twice as likely as insured women to delay filling needed prescriptions, more than twice as likely to delay crucial health screenings such as Pap smears, and more than twice as likely not to have received medical care (including preventive health care) within the past year. Furthermore, women without health insurance are more than four times as likely as women with health insurance to not have a regular doctor.[7]

For low-income women and girls, Medicaid – the publicly-funded health insurance program – provides a crucial safety net of health insurance coverage, and does so without full cost to the state since the federal government reimburses the state for more than half of Medicaid expenditures.[8] Federal standards require that Medicaid recipients be low-income and either children, pregnant women, parents of dependent children, or elderly, blind or disabled and eligible for federal Supplemental Security Income. States also have the option of expanding Medicaid coverage to other persons at higher income levels within these mandatory groups. Moreover, state's have the option of receiving waivers from the federal government that allow for expansions of coverage to other groups (such as the long-term unemployed.)

Women are more likely to be eligible for Medicaid than are men because women are more likely to be the primary caregivers of dependent children in single-parent households, because women tend to be poorer, and because women are more likely to live longer than men and therefore require Medicaid-supported long-term care for a

longer period of their lives. Nation-wide, women make up close to 70 percent of the population on Medicaid over the age of 15,[9] and in Massachusetts 76 percent of the adult family enrollees are women.[10] Nationally, Medicaid provides health insurance coverage for close to one in five children, and pays for close to 30 percent of the nation's childbirths. In Massachusetts, Medicaid pays for almost one in four childbirths.[11]

Because women are enrolled in Medicaid at higher rates than men, they are disproportionately affected by changes in Medicaid policy or practice. This is particularly the case when states react to declining revenues by attempting to rein in health care costs with restrictions to Medicaid eligibility or benefits.

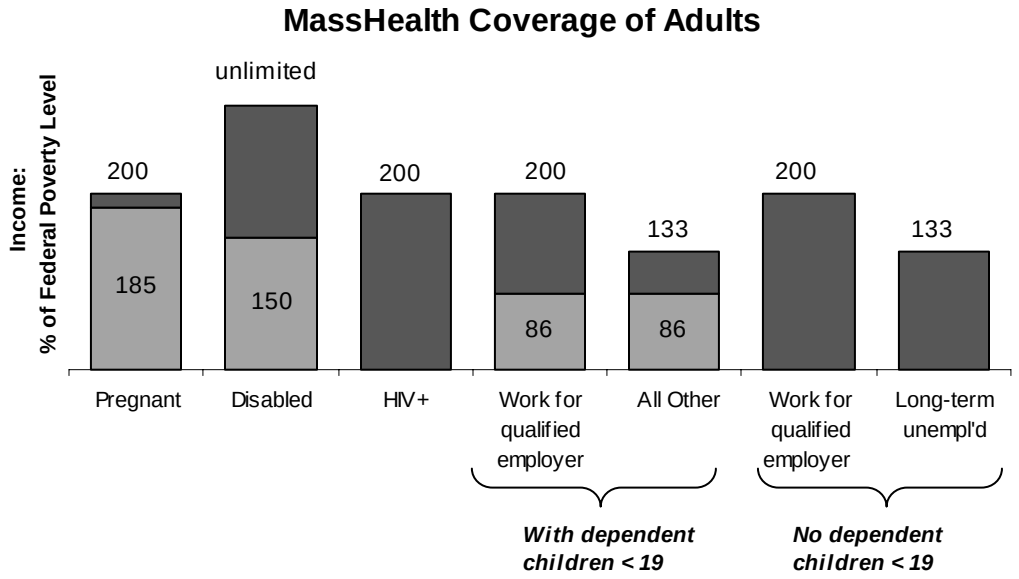
### *Medicaid Expansions in 1997*

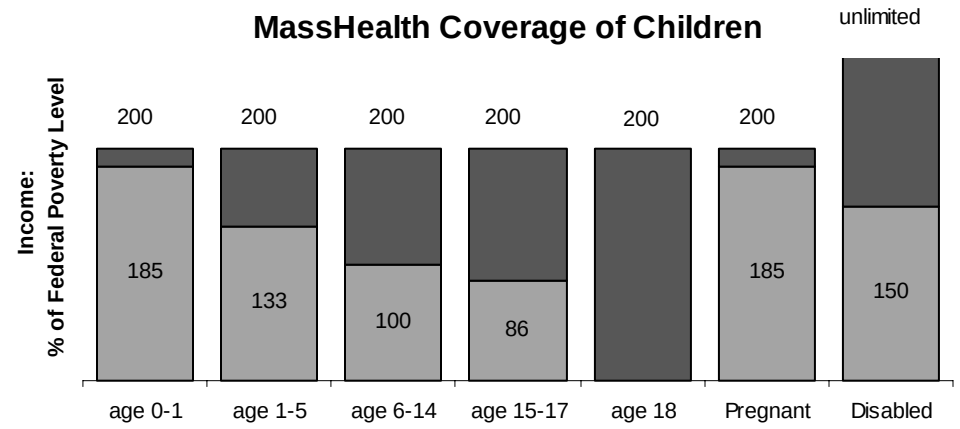
In 1997, Massachusetts initiated a major expansion of health care coverage through the Commonwealth's Medicaid program, also known as MassHealth. The intent of this expansion effort was to increase health insurance coverage among needy uninsured and underinsured residents. This expansion of the Medicaid program also provided the associated benefit of generating federal matching funds for additional enrollees, and also minimized the rapidly-growing costs associated with uncompensated care provided by the state's hospitals.[12]

In order to implement the expansions of MassHealth eligibility, the state received a waiver from the federal government (known as a Section 1115 waiver). This waiver allowed the state to expand eligibility for MassHealth beyond the mandated eligibility categories. Over the next two years, the state expanded eligibility for MassHealth from 86 percent of the federal poverty level to 133 percent for parents of dependent children, and provided coverage for all children under age 19 up to 200 percent of the federal poverty level. The state also expanded coverage for pregnant women from 185 percent of the poverty level to 200 percent. There were also expansion programs that provided premium assistance for private insurance coverage for childless adults up to 200 percent of the federal poverty level, and coverage for low-income people who are HIV-positive. There was expanded coverage as well for the long-term unemployed. In addition to these programmatic expansions for persons with low income, the Commonwealth expanded the MassHealth program to include people with disabilities of all income levels (see Figure 33).

Because these programs – the CommonHealth programs for children and adults – had previously been fully state funded, bringing them under the MassHealth program waiver allowed for a portion of the costs of coverage of these disabled individuals to receive federal matching dollars. The CommonHealth program provided these benefits, charging premiums to the enrollee, based on income.[13]

**Figure 33**



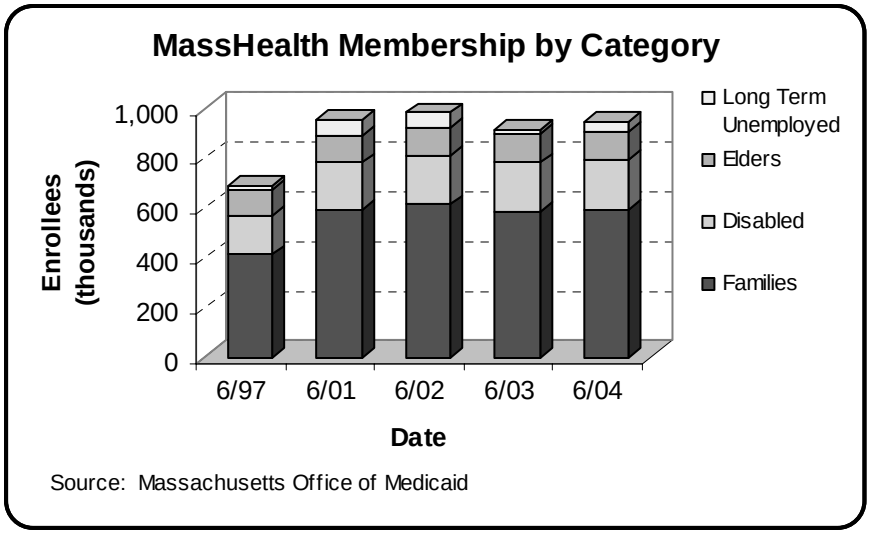

Expansion after 7/97

Base Population (eligible prior to 7/97)

Source: Quigley, Shelto and Turnbull, Massachusetts Health Policy Forum

These expansions in the late 1990's began a rapid increase in the number of people eligible for MassHealth, dramatically improving access to health care coverage for more low-income women and girls. For example, MassHealth membership quickly grew from close to 680,000 members in June 1997 to more than 950,000 in June 2001 with the addition of new population groups eligible for coverage (see Figure 34).[14]

**Figure 34**



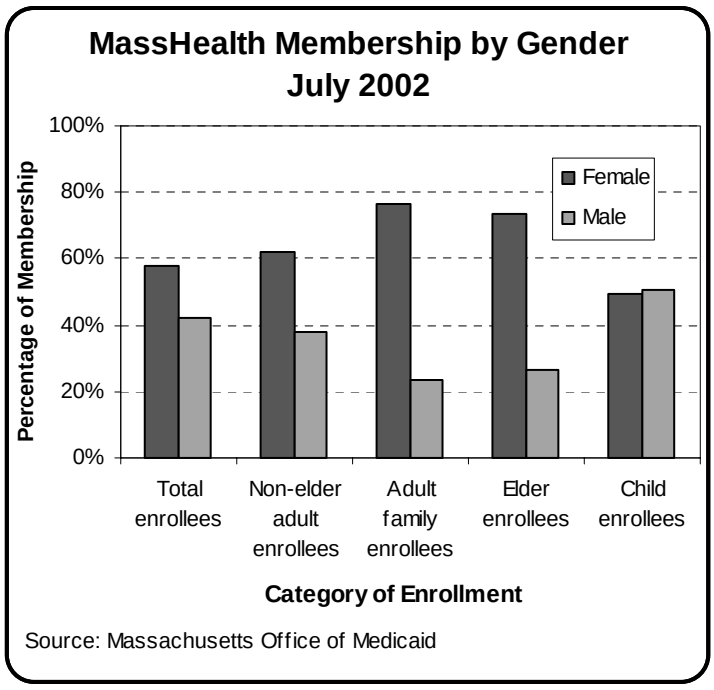

By 2001, family membership in MassHealth had grown by 43 percent over 1997. The Medicaid expansion programs allowed over 100,000 additional children and 80,000 additional parents to be added to the MassHealth programs.[15] Enrollment in the MassHealth programs reached a peak in August 2002, with an enrollment of just under 1,000,000 members – more than 570,000 adults, and more than 425,000 children.[16]

In Massachusetts, since close to two-thirds of adult enrollees are women, it is clear that the expansions of the MassHealth programs – particularly those that provided health insurance to an additional 100,000 children and 80,000 parents – provided health care security to tens of thousands of women and their families.

## Impact of Changes during the Fiscal Crisis

After 2001, appropriations for MassHealth grew at a faster rate than the rest of the state budget. However, these increases reflected dramatic rises in the cost of health care, and actually masked real cuts being made in MassHealth during this period. Starting in fiscal year 2002, the Commonwealth began implementing significant cutbacks in the MassHealth program with the stated intent of reducing costs. The impact of the fiscal crisis, therefore, did not show up primarily as budgetary funding decreases, but rather in a variety of programmatic cutbacks and policies that scaled back eligibility and benefits.[17]

**Figure 35**




Because the MassHealth program serves many more women than it does men, women were hard hit by the changes in Medicaid during the fiscal crisis (see Figure 35).[18] In July 2002, at the beginning of the state's fiscal crisis, among all enrollees the program was approximately 58 percent female. Looking at specific populations served by MassHealth, however, the percentages are more striking. Among all non-elder adults, 62 percent of the members were women. In July 2002, this was approximately 286,000 women. Among the adults who were eligible for MassHealth based on their status as being low-income parents ("adult family enrollees"), however, the percentage was even greater. Seventy-six percent of adult family enrollees were women – approximately 164,000.

As Figure 36 indicates, although the proportion of women enrolled in MassHealth has remained relatively stable since 2002, the numbers of women enrolled in the program have dropped (with the exception of elder enrollees.) The total number of women and girls receiving MassHealth dropped from approximately 578,000 in 2002 to 551,000 in 2004. The number of female non-elder adult enrollees dropped by approximately 17,000, and the number of women family members dropped by approximately 8,000.

**Figure 36**

**MassHealth Membership by Gender: July 2002 and July 2004**

| *2002* | *Female* | *Male* | *Total* |
|---|---|---|---|
| **Total** | **577,868** | **418,345** | **996,213** |
| Non-elder adult | 285,731 | 172,679 | 458,410 |
| Adult family | 164,243 | 50,470 | 214,713 |
| Elder | 84,821 | 30,978 | 115,799 |
| Child | 207,316 | 214,688 | 422,004 |
| *2004* | *Female* | *Male* | *Total* |
| **Total** | **550,600** | **394,007** | **944,607** |
| Non-elder adult | 268,765 | 157,571 | 426,336 |
| Adult family | 156,058 | 48,203 | 204,261 |
| Elder | 85,014 | 31,604 | 116,618 |
| Child | 196,821 | 204,832 | 401,653 |

Many factors contributed to this decline in the number of women and girls receiving health insurance through MassHealth: eligibility cutbacks, including the elimination of coverage for some immigrants; higher premiums and other out-of-pocket costs, which created burdens and discouraged participation for some; the

elimination of outreach programs that had been designed to help people enroll; people being "lost" during gaps in coverage; and other administrative changes in the programs that discouraged enrollment.

### *Elimination of Specific Benefits for Adults*

In March 2002, the state eliminated all dental benefits for adults on MassHealth, including dental hygiene, fillings, and other preventive dental care. There were estimates that eliminating this benefit would "save" $22 million, 50 percent of which would be a reduction in actual state costs and the other 50 percent would be foregone federal matching dollars.[19]

Because routine dental care is an important component of preventive medicine, attempts to realize cost savings in the short term could lead to higher costs over the longer term associated with the neglect of oral hygiene. For example, if a woman were to receive a routine oral exam, dental cleaning and have a dental cavity filled, the cost would have been approximately $137 in 2002. If that same woman were unable to pay for those routine dental procedures, and instead waited until she needed to go to a hospital emergency room for treatment, the cost of the exam, the extraction of a severely-damaged tooth, and the cost of partial dentures could cost as much as $343.[20]

Unfortunately, the reduction of dental health benefits can have a significant impact on the health of the low-income and disabled women who rely on the MassHealth programs for access to health care. Poor dental health can have obvious negative impacts on a woman's ability to eat healthfully, and has also been linked to heart disease, lung disease, and low birth weight infants. Without preventive dental care, a low-income woman's only recourse for severe tooth decay would be the extraction of affected teeth.

Starting in July 2002, the Commonwealth attempted to rein in skyrocketing drug costs by creating a list of higher cost prescription medications that would require prior authorization before a member could receive MassHealth coverage for the cost of that medication. As fiscal year 2003 progressed, more restrictions were added to coverage for additional classes of prescription drugs.

Effective January 2003, the Commonwealth eliminated MassHealth coverage for dentures, chiropractic therapy, prosthetic devices, orthotics and eyeglasses (although most orthotic and prosthetic benefits were restored by fiscal year 2004.) Again, eliminating coverage for prosthetic devices, chiropractics and eyeglasses has the potential for causing people to substitute higher-cost care that would be covered by insurance for these lower-cost services.

Other cuts in fiscal year 2003 included the discontinuation of coverage for emergency detoxification services, post-detoxification residential services for adults, and payment for acute hospital stays of more than twenty days for adults.

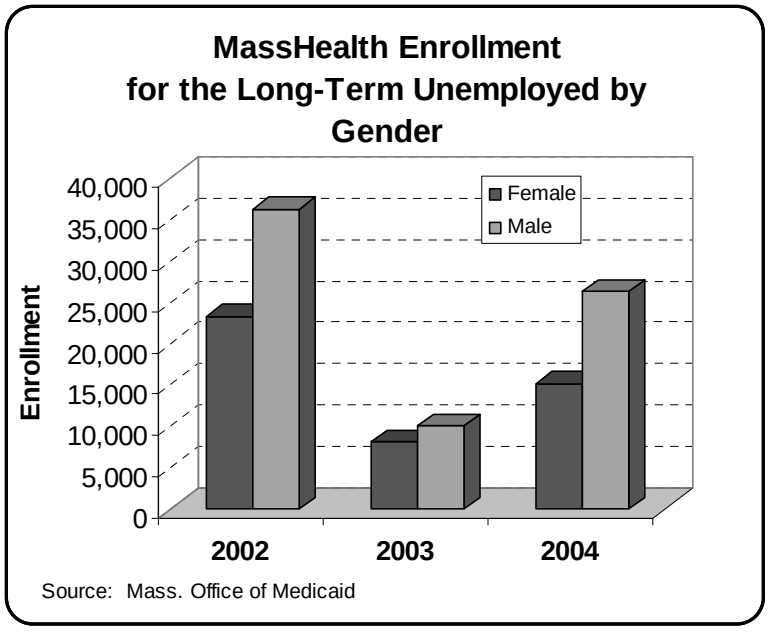
### *Reductions in MassHealth Eligibility*

Another approach to controlling MassHealth costs was to eliminate health care coverage for certain populations. Eliminating health insurance for low-income populations does not, however, prevent those persons from requiring health care. Instead, the lack of health insurance often delays accessing health care, and often results in ultimately more costly emergency care later on.

One of the programs eliminated at the start of the fiscal crisis was a planned expansion program for uninsured women with breast or cervical cancer. This program provided federal funding for screening for breast and cervical cancer, and then ensured federally-matched Medicaid coverage for treatment and follow-up for low-income women without insurance. In the beginning of 2003 emergency budget cuts delayed the start of this program, but funding for it was restored in fiscal year 2004.[21]

In April of 2003, the state removed close to 36,000 long-term unemployed adults from the MassHealth Basic program, leaving them without health insurance. Whereas in July 2002 there were approximately 23,000 long-term unemployed women enrolled in the MassHealth Basic program, by July 2003 there were just over 8,000 (see Figure 37.) When at the end of 2003 the state created a new, more limited MassHealth program called MassHealth Essential, it was assumed that many of those who had been cut from MassHealth Basic would enroll in this new program. However, by July 2004, there were approximately 15,000 women enrolled in the MassHealth programs for the long-term unemployed: 5,000 in MassHealth Basic, and 10,000 in MassHealth Essential.

**Figure 37**




Switching the benefits from MassHealth Basic to MassHealth Essential had significant implications for the persons receiving the coverage.

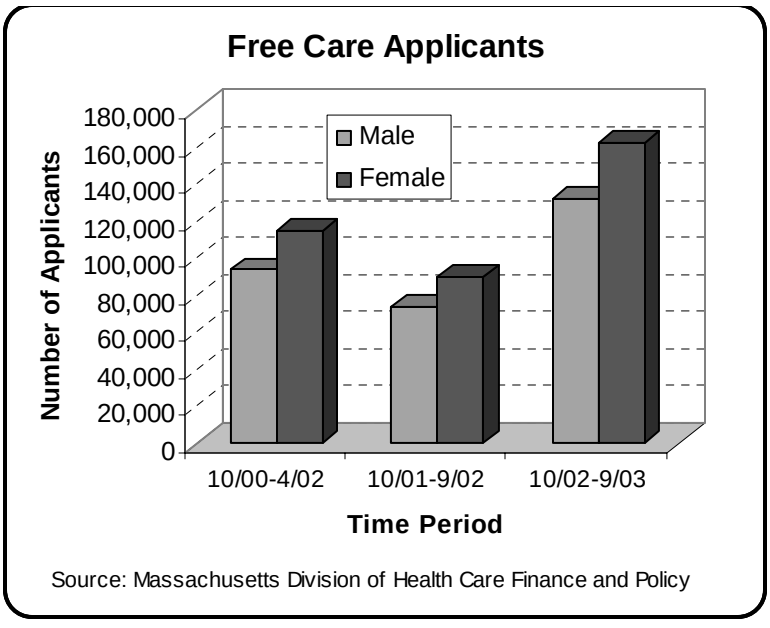
First of all, the MassHealth Essential program had a lower income eligibility threshold, and also provided fewer benefits than the MassHealth Basic program. Clearly, even though MassHealth Essential restored coverage to some long-term unemployed adults, the number never returned to its former level. Furthermore, with the gap in coverage, it is likely that some portion of potentially eligible adults were "lost" to the system during the transition from one program to the other.

Any time the state changes eligibility guidelines and some people lose coverage, those people are unlikely to receive appropriate preventive or primary care during that gap in coverage. In fact, lack of coverage and therefore a tendency to forego preventive and primary care tends to result in a population that is sicker and has higher-cost health needs.

Just as MassHealth Basic reduced its enrollment, the state saw demands on hospital emergency departments increase, as evidenced by the growing number of applicants for uncompensated or "free" care during this time (see Figure 38).[22] When MassHealth began its systematic program reductions in fiscal year 2002 and 2003, applications for free care increased by 79 percent, from more than 164,000 applicants to close to 295,000 applicants.

Even though the demand for free care increased during the fiscal crisis with the elimination of MassHealth Basic coverage and with the rapid increase in health care costs, the state eliminated funding in September 2002 for special demonstration projects that had been designed to reduce demands for "free" care by providing outreach for the MassHealth program or by providing access to other forms of primary care.

**Figure 38**




Source: Massachusetts Division of Health Care Finance and Policy

In fiscal year 2004, the Commonwealth attempted additional eligibility cuts that included asset tests for adults, and lowering the income eligibility threshold for persons receiving MassHealth in the HIV program. The Commonwealth lowered the eligibility threshold for the MassHealth HIV program to 133 percent of the poverty level (down from 200 percent.) Eligibility was returned to the 200 percent level in the fiscal year 2005 budget, and the proposed asset tests were never implemented. The fiscal year 2005 budget also allows 36,000 people to enroll in the

MassHealth Essential program, but if the program reaches that cap, the Commonwealth will initiate a waiting list and deny access to health insurance to those people unable to enroll.

In August 2003, 10,000 legal immigrants lost health care coverage under MassHealth. Of these low-income Massachusetts residents, 3,000 who were elderly or disabled immigrants had their coverage restored in June 2004, but this coverage was scheduled to run out in September 2004. Included in this group are persons who were fleeing persecution in their home countries awaiting asylum, as well as legal permanent residents who do not yet qualify for federal benefits. There is pending legislation that might allow the continued coverage of some of these immigrants, based on evaluation of certain aspects of their immigration status.

### *Increased Out-of-pocket Costs for MassHealth Members*

Another method by which the Commonwealth sought to stave off the rising costs of health care within the MassHealth program was to generate revenue by charging enrollees with increased co-payments, premiums and other out-of-pocket charges. Again, starting in January 2003, co-payments for prescription drugs increased from $0.50 to $2.00 per prescription. By fiscal year 2004, co-payments for certain prescription medications increased to $3.00.

There were also increases in the premiums for children on the Premium Assistance Program and the Family Assistance Program, increases in premiums for disabled children and adults on the CommonHealth program, and new premiums for enrollees with HIV. These premiums were targeted to families with incomes between 100 and 150 percent of the federal poverty level.

With the implementation of these premiums, the Commonwealth projected "saving" up to $15 million annually.[23] However, any time out-of-pocket costs are increased for low-income women, their ability to access health care for themselves and their children is threatened. There is a significant risk that out-of-pocket costs drive people to delay or forego needed care, once again risking the substitution of low-cost primary care with higher-cost emergency care.

Each of these steps to increase costs for participants in the MassHealth programs have the potential for limiting access to health care for women and girls across the state. Even as the Commonwealth moves out of the economic recession, the lingering impacts of the state's fiscal crisis have already had substantial impacts on the ability of women and girls across the state to gain access to affordable health care. Furthermore, any time that the Commonwealth reduces state spending on the Medicaid program, the state also is foregoing available federal Medicaid dollars that would have supported health care access for low-income women and girls.

[1] *Historic Health Insurance Tables,* "Table HI4: Health Insurance Coverage Status and Type of Coverage by State, All People: 1987-2003," U.S. Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements, last revised August 26, 2004, available at www.census.gov/hhes/hlthins/historic/hihistt4.html.

[2] "460,000 Massachusetts Residents Report That They Have No Health Insurance," press release from the Massachusetts Division of Health Care Finance and Policy, August 26, 2004, available at www.mass.gov/dhcfp. A comparison of survey methodologies by the Congressional Budget Office may explain some of the differences in the estimated numbers of uninsured individuals in Massachusetts. This comparison suggests that although the Census Bureau reports its findings as representing the number of people without health insurance for the entire year, their estimates may better reflect an estimate of the number of persons who have been without health insurance at a specific point during the year, as opposed to the number of people who have been uninsured for the entire year, or the number of people who have been without health insurance at any point during the year (Congressional Budget Office, "How Many People Lack Health Insurance and For How Long?" May, 12, 2003, available at www.cbo.gov). Furthermore, many of the national surveys base their estimations on assumptions that sometimes overestimate the number of uninsured individuals in Massachusetts. For example, a survey that uses national assumptions about the percentage of people receiving Medicaid may underestimate Medicaid coverage rates in Massachusetts because of this state's historically above-average income eligibility thresholds. Secondly, estimates about health insurance are sensitive to assumptions about rates of employer-provided insurance, which may also distort estimates.

[3] Medicaid enrollment numbers are from the Massachusetts Office of Medicaid MassHealth enrollment snapshots, uninsured estimates are from the Massachusetts Division of Health Care Finance and Policy, and population estimates are from the U.S. Census Bureau.

[4] "MassHealth Waiver Extension Request," Office of Medicaid, Commonwealth of Massachusetts, submitted June 30, 2004, p. 10.

[5] *A Profile of Health Among Massachusetts Adults, 2002: Results from the Behavioral Risk Factor Surveillance System*, Massachusetts Department of Public Health, April 2004, Table 2.1.

[6] "Women's Health Insurance Coverage," Kaiser Family Foundation, June 2004, available at www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=37684.

[7] All of the differences between uninsured women and insured women are statistically significant at $p < .05$. "Women's Health Insurance Coverage," Kaiser Family Foundation, June 2004, available at http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=37684.

[8] The Medicaid program is jointly funded by the federal and state governments. The net cost to the state of one dollar spent on Medicaid is typically fifty cents, although there are particular programs and services that receive a higher rate of federal reimbursement. Funding changes in Medicaid, therefore, do not have a direct one-to-one impact on the state budget, and in fact state funding cuts to Medicaid result in foregone federal revenue to the state.

[9] *Women's Access to Care: A State-Level Analysis of Key Health Policies*, Kaiser Family Foundation, June 2003, p. 41, available at www.kff.org/womenshealth/3326-index.cfm.

[10] Membership figures from the Massachusetts Office of Medicaid.

[11] Douglas Brown, "MassHealth Overview: March 2003," PowerPoint Presentation, available at www.bcbsfoundation.org/foundationroot/en_US/documents/massHealthoverview.pdf.

[12] Quigley, K., Shelto, A., and Turnbull, N., "MassHealth: Dispelling Myths and Preserving Progress," Issue Brief, Massachusetts Health Policy Forum, June 2002, p. 9.

[13] For a complete description of the eligibility guidelines for the various MassHealth programs in 2001 reflecting the major Medicaid expansions, see the health insurance resources "Roadmap" at the Center for Health Policy and Research at the University of Massachusetts Medical School, available at www.umassmed.edu/healthpolicy/roadmap.

[14] Membership figures from the Massachusetts Office of Medicaid.

[15] Greenberg, Josh, *The Facts on MassHealth: What it Is. Why it Works*, Health Care for All, March 2002, p. 4.

[16] Membership figures from the Massachusetts Office of Medicaid.

[17] For a comprehensive listing of the reductions in eligibility and benefits, and the increases in out-of-pocket costs for enrollees, see "Chronology of Health Access Cutbacks in 2002-2004," compiled by the Massachusetts Law Reform Institute, February 2004, available at www.masslegalservices.org/docs/Cutbacks_2002-4_Highlights.doc.

[18] Membership figures from the Massachusetts Office of Medicaid.

[19] *The MassHealth Cuts: What They Are. Why They Don't Work. What We Can Do*, Health Care For All, November 13, 2002, p. 1, available at www.hcfama.org.
[20] Testimony by Robert Alconada, Massachusetts Dental Society, April 9, 2002, cited in: *The MassHealth Cuts: What They Are. Why They Don't Work. What We Can Do,* Health Care For All, November 13, 2002, p. 11, available at www.hcfama.org.
[21] *The People's Budget for Fiscal Year 2004*, Massachusetts Human Services Coalition, p. 25.
[22] See Quigley, K., Shelto, A., and Turnbull, N., "MassHealth: Dispelling Myths and Preserving Progress," Issue Brief, Massachusetts Health Policy Forum, June 2002, p. 12-13, and also *Uncompensated Care Pool Annual Reports*, Massachusetts Division of Health Care Finance and Policy, available at www.mass.gov/dhcfp/pages/dhcfp_22.htm#gen_info.
[23] *The People's Budget for Fiscal Year 2004*, Massachusetts Human Services Coalition, p. 17.